Telehealth for Medicare Advantage Risk Adjustment and Quality

I. Telehealth Services & Risk Adjustment

Telehealth refers to a broad collection of electronic and telecommunications technologies that support delivery of health care services from distant locations. Forms of telehealth include Telemedicine, Virtual Check-Ins, E-Visits, and Telephone visits, among others.

Risk Adjustment, meanwhile, requires that reported diagnoses stem from face-to-face visits between patients and providers. Telehealth services that employ synchronous *audio and video* technology that permits communication between patients and providers in real time meet risk adjustment's face-to-face requirement.

A. Telemedicine

Telemedicine is the practice of medicine using technology to deliver care at a distance. A practitioner in one location (distant site) uses telecommunications to deliver care to a patient at another location (originating site).

These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

Services that can be provided via telemedicine include, among others, office/outpatient visits, annual wellness visits, emergency department or initial inpatient consultations, ESRD- related services, individual and group diabetes self-management training, and individual psychotherapy.

Practitioners who can furnish who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers, and registered dietitians.

Telemedicine Requirements

Established patient/provider relationship

Originating Site *(patient's location)*

II. A rural setting that is:

- In a county outside a Metropolitan Statistical Area (MSA), or
- A rural Health Professional Shortage Area (HPSA) in a rural census tract

**Originating site geographic conditions do not apply to: hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and patient homes when practitioners furnish either monthly home dialysis ESRD-related medical evaluations or treatment of a substance use disorder or a co-occurring mental health disorder.*

III. Patient Location

- A medical facility, such as physician office, Hospital, Critical Access Hospital (CAH), Rural Health Clinic, Federally Qualified Health Center, Hospital-based or CAH-based Renal Dialysis Center, Skilled Nursing Facility (SNF), Community Mental Health Center, Renal Dialysis Facility, Mobile Stroke Unit, or
- Homes of beneficiaries with either End-Stage Renal Disease (ESRD) getting home dialysis, or substance use disorders receiving treatment for same (or a co-occurring mental health disorder)

Technology: The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient

**Transmitting medical information to a practitioner who reviews it later, an asynchronous telecommunications system, is permitted in Alaska and Hawaii.*

Risk Adjustment

The utilization of synchronous *audio and video* technology permitting real-time interaction makes Telemedicine visits acceptable for risk adjustment.

Telemedicine Coding and Billing

Telemedicine does not require a distinct set of CPT/HCPCS codes. Any services furnished via telemedicine are reported utilizing the same codes that are employed when an in-person visit takes place.

Distant Site Billing *(location of servicing provider)*

1. CPT/HCPCS Codes

New Patient Office/Outpatient Visit:

	History	*Exam*	*MDM*
99201	Problem focused	Problem focused	Straightforward
99202	Expanded problem focused	Expanded problem focused	Straightforward
99203	Detailed	Detailed	Low
99204	Comprehensive	Comprehensive	Moderate
99205	Comprehensive	Comprehensive	High

**Requires all 3 Components: History, Exam, and Medical Decision Making (MDM)*

Due to the COVID-19 emergency, Medicare has expanded telehealth coverage and eased current rules, such as the telemedicine originating site requirements. Patient homes can now serve as originating sites, regardless of diagnosis, for the duration of the COVID-19 crisis. See CMS' General Provider Telehealth and Telemedicine Tool Kit for details. This document provides a broad overview of common telehealth services and is for informational purposes only. Please refer to the resources listed for the most up to date information.

Established Patient Office/Outpatient Visit:

	History	*Exam*	*MDM*
99212	Problem focused	Problem focused	Straightforward
99213	Expanded problem focused	Expanded problem focused	Low
99214	Detailed	Detailed	Moderate
99215	Comprehensive	Comprehensive	High

**Requires 2 of 3 Components: History, Exam, and Medical Decision Making (MDM)*

2. Place of Service (POS) Code
   - 02 – Telehealth
3. Modifiers
   - 95 – Synchronous telemedicine service rendered via real-time interactive audio/video system
   - *GT – via interactive audio/video system
   - GQ – via asynchronous system *(for use in Alaska and Hawaii)*

**CAHs billing for telehealth services under CAH Optional Payment Method II should submit institutional claims using modifier GT*

Originating Site Billing

- Q3014 – Originating site facility fee

**Applicable when patient presents to a medical facility as originating site. This fee does not apply when the home serves as the originating site.*

Telemedicine Documentation Tips

- When >50% of the total visit time is spent counseling, document the total visit time + topics discussed to meet CPT requirements.
- All chronic, active, or status (amputations, dialysis status, etc.) conditions that impact the current date of service should be clearly documented.
- Specify a condition's acuity or severity
- Do not use broad terms when a more specific diagnosis is available
- Avoid the phrase "history of" when documenting active conditions that impact the member's current encounter
- All records should have a valid signature including an authentication statement and the rendering provider's credentials.

B. Virtual Check-Ins

Virtual check-ins are short (5-10 minutes), patient-initiated communication with a practitioner for patients to check in with their doctor to determine whether an office visit or other service is needed, or remote evaluation of recorded video and/or images submitted by patient.

**The communication should not be related to a medical visit within the previous 7 days and should not lead to a medical visit within the next 24 hours (or soonest appointment available), otherwise it's bundled into the E/M service.*

Practitioners who can furnish the service are physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers.

Documentation: Verbal consent should be noted in the medical record for the service, five to 10 minutes of medical discussion should be documented, along with a statement that the patient does not require a visit unless there is a problem.

Virtual Check-In Requirements

Established patient/provider relationship

Originating Site

1. Geographic area – All areas
2. Patient Location – All locations, including patient's home

Technology: Communication may take place via a number of modalities including synchronous discussion over a telephone or exchange of information through video or image. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

Risk Adjustment

Virtual Check-Ins are not acceptable for CMS-operated risk adjustment programs.

Virtual Check-Ins – Coding and Billing

G2010	Remote evaluation of pre-recorded info
G2012	Virtual check-in
G0071	RHC/FQHC communications services

C. E-Visits

E-visits are patient-initiated communications through an online patient portal. Once a patient generates the initial inquiry communications can occur over a 7-day period.

Practitioners who can furnish the service include physicians, nurse practitioners (NPs), physician assistants (PAs), and other clinicians who are able to bill for E/M services independently, as well as physical therapists (PTs), occupational therapists (OTs), speech language pathologists, clinical psychologists, and other health care professionals not able to bill E/M services independently.

E-Visit Requirements

Established patient/provider relationship

Originating Site

Geographic area – All areas

Patient Location – All locations, including patient's home

Technology: Patient Portal

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Risk Adjustment

E-visits are not acceptable for CMS-operated risk adjustment programs.

E-Visits – Coding and Billing

Physicians, NPs, and PAs:

99421	Non face-to-face online digital E/M service, established patient, up to 7 days, 5-10 minutes
99422	Non face-to-face online digital E/M service, established patient, up to 7 days, 11-20 min.
99423	Non face-to-face online digital E/M service, established patient, up to 7 days, 21+ minutes

Physical or Occupational Therapy, SLP, clinical Psych:

G2061	Non face-to-face online digital E/M service, established patient, up to 7 days, 5-10 minutes
G2062	Non face-to-face online digital E/M service, established patient, up to 7 days, 11-20 min.
G2063	Non face-to-face online digital E/M service, established patient, up to 7 days, 21+ minutes
98970	Non face-to-face online digital E/M service, established patient, up to 7 days, 5-10 minutes
98971	Non face-to-face online digital E/M service, established patient, up to 7 days, 11-20 min.
98972	Non face-to-face online digital E/M service, established patient, up to 7 days, 21+ minutes

**Medicare does not accept CPT codes 98970-98972. E-visit services furnished by clinicians unable to report E/M services independently to Medicare beneficiaries must be reported utilizing a code from the G2061-G2063 code series.*

D. Telephone Visits

Telephone Visits are non-face-to-face, patient-initiated services over the telephone.

**The communication should not be related to a medical visit within the previous 7 days and should not lead to a medical visit within the next 24 hours (or soonest appointment available).*

Practitioners who can furnish telephone visits include physicians, NPs, PAs and other clinicians who are able to bill for E/M services independently, plus PTs, OTs, clinical psychologists, registered dietitians and other health care professionals not able to bill E/M services independently.

Telephone Visit Requirements

Established patient/provider relationship

Risk Adjustment

Telephone visits are not acceptable for CMS-operated risk adjustment programs.

Telephone Visits – Coding and Billing

Physicians, NPs, and PAs:

99441	Telephone E/M service provided to an established patient, parent, or guardian; 5-10 minutes
99442	Telephone E/M service provided to an established patient, parent, or guardian; 11-20 minutes
99443	Telephone E/M service provided to an established patient, parent, or guardian; 21-30 minutes

Phys. or Occup. Therapy, SLP, clinical Psych:

98966	Telephone assessment and management service provided to an established patient, parent, or guardian; 5-10 minutes
98967	Telephone assessment and management service provided to an established patient, parent, or guardian; 11-20 minutes
98968	Telephone assessment and management service provided to an established patient, parent, or guardian; 21-30 minutes

Resources

Center for Connected Health Policy: State Telehealth Laws and Reimbursement Policies
https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies

CMS – Applicability of diagnoses from telehealth services for risk adjustment
https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf

CMS – General Provider Telemedicine and Telehealth Toolkit
https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf

Medicare Learning Network (MLN) Booklet – Telehealth Services
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Medicare Telehealth Frequently Asked Questions (FAQs)
https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

Medicare Telemedicine Health Care Provider Fact Sheet
https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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II. COVID-19 Public Health Emergency (PHE) & Telehealth Expansion

Telemedicine during the PHE

As of March 1, 2020, the Centers for Medicare and Medicaid Services (CMS) will make payments for Medicare telehealth services furnished to patients in broader circumstances so that beneficiaries can receive healthcare without having to travel to a healthcare facility during the COVID-19 Public Health Emergency.

These benefits are being expanded on a **temporary and emergency basis** under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

Temporary Changes to Telemedicine Requirements

New patient/provider relationship will be allowed

- Even though an established relationship is still required, HHS has announced that they will **not** conduct audits to ensure that such a prior relationship existed for claims submitted during the PHE

Originating Site *(patient's location)*

- Geographic Area – telemedicine will be allowed in all areas of the country and in all settings
- Patient Location – telemedicine restrictions on a patient's location during a visit have been waived. Any healthcare facility or the patient's home will be accepted.

Technology

A provider can use any non-public facing remote communication product that is available to communicate with patients as long as the technology has audio and video capabilities that are used for two-way, real-time interactive communication. HHS will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through technologies such as FaceTime or Skype.

Note: Audio-only consults are still prohibited for telemedicine. See Telephone Visits below.

Prescribing Controlled Substances

Prescriptions for all schedule II-V controlled substances may be issued without an in-person medical evaluation if all of the following requirements are met: The prescription is for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice; The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and the practitioner is acting in accordance with applicable Federal and State laws.

Risk Adjustment Note: Due to the expansion of virtual care, organizations that submit diagnoses for CMS-operated risk adjusted payment are able to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service, and from a face-to-face encounter (Telephone visits are not acceptable for Risk Adjustment).

Telephone Visits

In ordinary circumstances, telephone evaluation and management (E/M) visits (CPT codes 98966-98968 and 99441-99443) are recognized as non-covered services for Medicare beneficiaries. If the needs of the patient are significant enough to require the amount of time and attention from the provider specified in the codes for higher level telephone E/M services, either an in-person visit or telemedicine visit would be required.

Temporary Changes to Telephone Visit Requirements

CMS has recognized that in the context of trying to reduce exposure risks associated with the PHE for the COVID-19 pandemic, two-way audio and video technology may not be available to all beneficiaries. During the PHE, separate payments will be made for CPT codes 98966-98968 and CPT codes 99441-99443.

Evaluation and Management (E/M) Visits

The current E/M coding guidelines preclude the billing practitioner from selecting the office/outpatient E/M code level based on time in circumstances where the practitioner is not engaged in counseling and/or care coordination.

Temporary Changes to E/M Visit Requirements

The E/M level selection furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter. The requirement to document the history and/or physical exam in the medical record has been removed temporarily.

Coding and Billing for Telehealth

With the expansion of services due to the PHE, all telehealth services should be billed with place of service 02 and modifier 95 should be appended when appropriate.

Resources

Centers for Medicare & Medicaid Services: Medicare Telemedicine Health Care Provider Fact Sheet
https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Centers for Medicare & Medicaid Services: Applicability of diagnoses from telehealth services for risk adjustment
https://www.cms.gov/files/document/applicability-diagnoses-telehealth-services-risk-adjustment-4102020.pdf

Department of Health & Human Services CCIIO: Risk Adjustment FAQ on COVID-19
https://www.cms.gov/files/document/RA-Telehealth-FAQ.pdf

Federal Register: Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency
https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public

U.S. Department of Health & Human Services: Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency
https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

U.S. Department of Justice Drug Enforcement Administration: Telemedicine
https://www.deadiversion.usdoj.gov/coronavirus.html

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III. Telehealth & HEDIS – Using Technology to Deliver Quality Care

Just as technology can be used to deliver care remotely, certain quality measures can be completed via telehealth.

A. Prevention and Screening

1. Care for Older Adults (COA)

The percentage of adults 66 years and older who had each of the following during the measurement year. Report each of the four rates separately:

- Advance care planning,
- Medication review,
- Functional status assessment,
- Pain assessment

HEDIS Value Set

Advance Care Planning: 99483, 99497, 1123F, 1124F, 1157F, 1158F, S0257
Medication Review: 90863, 99605, 99606, 1159F, 1160F, G8427
Functional Status Assessment: 99483, 1170F, G0438, G0349
Pain Screening: 1125F, 1126F
Transition of Care 7 Days: 99496
Transition of Care 14 Days: 99495

2. Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)

Assesses children and adolescents 3-17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of:

- *Body mass index (BMI) percentile documentation,
- Counseling for nutrition,
- Counseling for physical activity

**Weight Assessment and documentation of BMI not applicable for telehealth as self-reported biometrics do not close WCC measure*

HEDIS Value Set

***ICD-10-Dx Codes:** Z68.51-Z68.54
Counseling for Nutrition
Nutritional Counseling: 97802-97804, G0270, G0271, G0447, S9449, S9452, S9470ICD-10-CM: Z71.3 (Dietary counseling and surveillance)
Counseling for Physical Activity
Non-physician Exercise Class: S9451
ICD-10-CM: Z02.5 (Encounter for sports physical), Z71.82 (Encounter for exercise counseling)

B. Medication Management and Care Coordination

1. Medication Reconciliation Post-Discharge (MRP)

Assesses whether adults 18 years and older who were discharged from an inpatient facility had their medications reconciled within 30 days.

HEDIS Value Set

CPT/HCPCS: 99483, 99495, 99496
CPTII: 1111F
Telephone Visits: 98966-98968, 99441-99443

2. Transitions of Care (TRC)

Percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported:

- Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission or the following day.
- Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge or the following day.
- Patient Engagement after Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

**Follow-up visit and Medication Reconciliation may be completed by Telehealth visit.*

***Notification of admission and discharge must be found in provider medical record.*

HEDIS Value Set

CPT/HCPCS: 99483, 99495, 99496
CPTII: 1111F
Telephone Visits: 98966-98968, 99441-99443

C. Access/Availability of Care

1. Adults' Access to Preventive/Ambulatory Health Services (AAP)

Assesses members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.

HEDIS Value Set

ICD-10-Dx:
General Medical Exam: Z00.00, Z00.01
CPT Codes:
18–39 Years Old: 99385, 99395
40–64 Years Old: 99386, 99396
65+ Years: 99387, 99397
HCPCS Codes:
Initial Preventive Physical Examination: G0402*
Annual Wellness Visit: G0438, G0439

**Medicare has not approved the use of telemedicine to furnish the Initial Preventive Physical Examination (IPPE), HCPCS G0402*

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2. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Assesses whether children/adolescents 1-17 years of age who had a new prescription for an antipsychotic medication had documentation of psychosocial care as first-line treatment before being prescribed an antipsychotic.

HEDIS Value Set

ICD-10-CM: F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F28.9, F22-F24, F28, F29, F30.10-F30.13, F30.2-F30.4, F30.8, F30.9, F31.10-F31.13, F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.78, F32.3, F33.3, F84.0, F84.2, F84.3, F84.5, F84.8, F84.9, F95.0-F95.2, F95.8, F95.9

Psychosocial Care: 90832-90834, 90836-90840, 90845-90847, 90849, 90853, 90875, 90876, 90880

HCPCS Psychosocial Care: G0176, G0177, G0409-G0411, H0004, H0035-H0040, H2000, H2001, H2011-H2014, H2017-H2020, S0201, S9480, S9484, S9485

3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of the diagnosis,
- Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit

HEDIS Value Set

CPT/HCPCS: 98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510, 98966-98968, 99441-99443, 98970-98972, 99421-99423,H0033, J0570-J0575, J2315, S0109, Q9991, Q9992, G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034-H0037, H0039, H0040, H0047, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255

4. Prenatal and Postpartum Care (PPC)

Assesses important facets of prenatal and postpartum care:

- Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.
- Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

**Follow-up appointment will be required.*

HEDIS Value Set

Prenatal Care

ICD-10-CM: Use appropriate code family: O; Z03.71-Z03.75, Z03.79, Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93, Z36, Z36.0-Z36.5, Z36.81-Z36.89, Z36.8A, Z36.9
E/M Service: 99201-99205, 99211-99215, 99241-99245, 99500
Prenatal Bundled Codes: 59400, 59425, 59426, 59510, 59610, 59618

Postpartum Care

ICD-10-CM: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
E/M Service: 99501
Postpartum Bundled Codes: 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622
Cervical Cytology: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
CPT: 57170, 58300
CPTII: 0503F

D. Overuse/Appropriateness

1. Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB)

Assesses percentage of members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis and who were not dispensed an antibiotic prescription (a higher rate is better).

HEDIS Value Set

ICD-10-CM: J20.3-K20.9, J21.0, J21.1, J21.8, J21.9
Telephone Visits: 98966-98968, 99441-99443

2. Use of Imaging Studies for Low Back Pain (LBP)

Assesses members 18–50 years old with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis (a higher score indicates better performance).

HEDIS Value Set

ICD-10-CM: M47.26-M47.28, M47.816-M47.818, M47.896-M47.898, M48.06, M48.061, M48.062, M48.07, M48.08, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M53.2X6-M53.2X8, M53.3, M53.86-M53.88, M54.16-M54.18, M54.30-M54.32, M54.40-M54.42, M54.5, M54.89, M54.9, M99.03, M99.04, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110A, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.092A. S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XS

CPT: 98970-98972, 99421-99423, 98966-98968, 99441-99443, 72020, 72052, 72100, 72110, 72114, 72120, 72131-72133, 72141, 72142, 72146-72149, 72156, 72158, 72200, 72202, 72220

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3. Use of Opioids From Multiple Providers (UOP)

The proportion of members 18 years and older, receiving prescription opioids for >15 days during the measurement year who received opioids from multiple providers.

Three rates are reported:

- Multiple Prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year
- Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year
- Multiple Prescribers and Multiple Pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

HEDIS Value Set

ONLY Exclusion codes on the HEDIS Value Set

E. Respiratory Conditions

1. Asthma Medication Ratio (AMR)

Assesses the percentage adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

HEDIS Value Set

ICD-10-CM: E84.0, E84.11, E84.19, E84.8, E84.9,J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9,J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998, J68.4, J96.00-J96.02, J96.20-J96.22

Telephone Visits: 98966-98968, 99441-99443

2. Appropriate Treatment for Upper Respiratory Infection (URI)

Assesses children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

HEDIS Value Set

ICD-10-CM: J00, J06.0, J06.9

CPT: 98966-98968, 99441-99443

99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, G0402, G0438, G0439, G0463, T1015

CPTII: 3074F, 3075F, 3077F, 3078F, 3079F, 3080F

Remote BP Monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457

Online Assessments: 98970-98972, 99421-99423

Telephone Visits: 98966-98968, 99441-99443

F. Cardiovascular Conditions

1. Controlling High Blood Pressure (CBP)

Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

**Follow-up appointment will be required.*

**This measure may be closed via telehealth only when blood pressure readings are submitted by Remote BP Monitoring. Self-reported blood pressure readings cannot be used to close the CBP measure.*

HEDIS Value Set

E/M Service: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, G0402, G0438, G0439, G0463, T1015

CPTII: 3074F, 3075F, 3077F, 3078F, 3079F, 3080F

Remote BP Monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457

Online Assessments: 98970-98972, 99421-99423

Telephone Visits: 98966-98968, 99441-99443

2. Statin Use in Persons with Cardiovascular Disease (SPC)

Assesses males 21–75 years of age and females 40–75 years of age who have clinical atherosclerotic cardiovascular disease (ASCVD) and who meet the following criteria:

- Received Statin Therapy: Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year
- Statin Adherence 80%: Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period

HEDIS Value Set

ICD-10-CM: I21.01, I21.02, I21.09, I21.11, 121.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0-I23.8, I25.2

CPT: 33510-33514, 33516-33519, 33521-33523, 33533-33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

G. Diabetes

1. Comprehensive Diabetes Care (CDC)

Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing, HbA1c poor control

CDC continued:

(>9.0%), HbA1c control (<8.0%), HbA1c control (<7.0%) for a selected population,

- Eye exam (retinal) performed,
- Medical attention for nephropathy,
- BP control (<140/90 mm Hg)

**Additional exclusion criteria are required for this indicator, which will result in a different eligible population from all other indicators.*

***Telehealth will not close the Hba1c, Nephropathy, Eye exam or blood pressure gap unless submitted by Remote BP Monitoring or in-home testing kits.*

****Follow-up appointment will be required.*

HEDIS Value Set

HbA1c
CPT: 83036, 83037
CPTII: 3044F, 3045F, 3046F, 3051F, 3052F

Eye Exam (Retinal) Performed
Diabetic Retinal Screening w/ Eye Care Professional Performed, Results Documented and Reviewed: 2022F, 2023F, 2024F, 2025F, 2026F, 2033F
No Evidence of Retinopathy in Prior Year: 3072F

Kidney Disease Monitoring
Labs: 81000-81003, 81005, 82042-82044, 84156
CPTII: 3060F, 3061F, 3062F, 3066F, 4010F

Control of Blood Pressure
CPTII: 3074F, 3075F, 3077F, 3078F, 3079F, 3080F
Remote BP Monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457
Online Assessments: 98970-98972, 99421-99423
Telephone Visits: 98966-98968, 99441-99443

2. Statin Therapy for Patients with Diabetes (SPD)

Assesses adults 40-75 years of age who have diabetes and who do not have clinical ASCVD, who meet the following criteria:

- Received Statin Therapy: Members who were dispensed at least one statin medication of any intensity during the measurement year
- Statin Adherence 80%: Members who remained on statin medication of any intensity for at least 80% of the treatment period

HEDIS Value Set

ICD-10-CM: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I21.9, I21.A1, I21.A9, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0-I23.8, I25.2
CPT: 33510-33514, 33516-33519, 33521-33523, 33533-33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92982, 92995, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

I. Musculoskeletal Conditions

1. Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Assesses percentage of members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

HEDIS Value Set

HCPCS Codes:
DMARDs: J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310, Q5102-Q5204
NEW: J9311, J9312, Q5109
Telephone Visits: 98966-98968, 99441-99443

2. Osteoporosis Management in Women Who Had a Fracture (OMW)

Assesses the percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

HEDIS Value Set

Bone Mineral Density Tests
CPT Codes: 76977, 77078, 77080-77082, 77085, 77086
Osteoporosis Therapy (after fracture) HCPCS: J0897, J1740, J3110, J3489
Telephone Visits: 98966-98968, 99441-99443

J. Behavioral Health

1. Follow Up Care for Children Prescribed ADHD Medication (ADD)

The two rates of this measure assess follow-up care for children prescribed an ADHD medication:

- Initiation Phase: Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.
- Continuation and Maintenance Phase: Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days, and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase.

HEDIS Value Set

CPT/HCPCS: 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99510, G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2010, M0064, S0201, S9480, S9484, S9485, T1015
Telephone Visits: 98966-98968, 99441-99443

ADD continued:

Initiation Phase
90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876
C&M Phase
99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

2. Antidepressant Medication Management (AMM)

Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.

Two rates are reported:

- Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks),
- Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months)

HEDIS Value Set

ICD-10-CM: F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9
CPT: 98966-98968, 99441-99443

3. Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Assesses emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

- ED visits for which the member received follow-up within 30 days of the ED visit (31 total days),
- ED visits for which the member received follow-up within 7 days of the ED visit (8 total days)

HEDIS Value Set

CPT/HCPCS: 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99510, 98970-98972, 99421-99423, 98966-98968, 99441-99443, G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034-H0037, H0039, H0040, H0047, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255

4. Follow Up After Hospitalization for Mental Illness (FUH)

Assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had a follow-up visit with a mental health practitioner.

Two rate are reported:

- The percentage of members with a follow-up within 7 days of discharge,
- The percentage of members with a follow-up within 30 days of discharge

HEDIS Value Set

CPT/HCPCS: 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99510, G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010-H2020, M0064, T1015, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255

5. Follow Up After Emergency Department Visit for Mental Illness (FUM)

Assesses emergency department (ED) visits for adults and children 6 years of age and older with a principal diagnosis of mental illness, or intentional self-harm, and who received a follow-up visit for mental illness. Two rates are reported:

- ED visits for which the member received follow-up within 30 days of the ED visit (31 total days),
- ED visits for which the member received follow-up within 7 days of the ED visit (8 total days)

HEDIS Value Set

CPT/HCPCS: 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99510, G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010-H2020, M0064, T1015, 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255

6. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Assesses adults 19–64 years of age who have schizophrenia and were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

HEDIS Value Set

HCPCS: J2794, J0401, J1631, J2358, J2426, J2680, C9035, C9037

